NEW PATIENT INFORMATION

PATIENT NAME: _____

Please list any medications, including the dose and frequency taken, (please include vitamins/supplements)

MEDICATION: **Reason or diagnosis for taking the medication:**

_____ _____

_____ _____

_____ _____

Please list any allergies to medication : _____

Please list any surgeries and the year performed:

_____

_____

Family History: **Chronic Health Problems:**

Mother: Alive/Deceased _____ _____

Father: Alive/Deceased _____ _____

Social History:

Martial Stauts: _____ Education: _____ Work Status: _____ Occupation: _____

Children: How many? _____

Tobacco Use? ☐ Yes ☐ No

If yes, how much per day? _____ For how many years? _____

Alcohol Use? ☐ Yes ☐ No

If yes, how many drinks per week: _____

Any past or present drug use? ☐ Yes ☐ No

If yes, what kind and how much? _____

Health Maintenance: Have you had any of the following? Year?

☐ Bone Density _____	☐ Colonoscopy _____	☐ Flu Vaccine _____
☐ Mammo _____	☐ Mammogram _____	☐ PAP Smear _____
☐ Pneumovax Vaccine	☐ Shingles Vaccine _____	☐ Tetanus _____
☐ PSA Level _____	☐ Prevnar _____	

Previous Primary Care Physician: _____